Complete Summary

GUIDELINE TITLE

Screening for skin cancer: recommendations and rationale.

BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening for skin cancer. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):44-6. [9 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Skin cancer:

- Malignant melanoma
- Basal cell carcinoma
- Squamous cell carcinoma

GUIDELINE CATEGORY

Screening

CLINICAL SPECIALTY

Dermatology
Family Practice
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To present recommendations for screening for skin cancer
- To update the 1995 recommendations contained in the Guide to Clinical Preventive Services, second edition

TARGET POPULATION

The general population

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for skin cancer using a total-body skin examination

MAJOR OUTCOMES CONSIDERED

Morbidity and mortality associated with skin cancer

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

To find relevant articles on screening for skin cancer, the Evidence-based Practice Center staff searched the MEDLINE database for papers published from January 1994 to June 1999, using search terms for screening, physical examination, morbidity, and skin neoplasms. For information on accuracy of screening tests, the Evidence-based Practice Center staff used the search term "sensitivity and specificity." Additional search terms were added to locate articles for background on skin cancer morbidity and mortality and on epidemiology. The search was updated monthly during the course of the project. The Evidence-based Practice Center staff also used reference lists and expert recommendations to locate additional articles published after 1994. Search terms are listed in Appendix I of the technical companion document (Screening for skin cancer. Rockville (MD): Agency for Healthcare Research and Quality [AHRQ], 2001. [Systematic evidence review; no. 2]).

Two reviewers independently reviewed a subset of 500 abstracts. Once consistency was established, 1 reviewer reviewed the remainder. Studies were included if they contained data on yield of screening, screening tests, risk factors, risk assessment, effectiveness of early detection, or cost effectiveness. Of 54 included studies, 5 contained data on accuracy of screening tests, 24 contained data on yield of screening, 7 contained data on stage or thickness of lesions found through screening, 11 addressed risk assessment, and 7 addressed the effectiveness of early detection (some studies addressed more than one topic). The full text of these articles was retrieved and the data abstracted. In addition, the full text of 47 studies of various risk factors for skin cancer was retrieved. These articles were read but not systematically abstracted.

The most important studies from before 1994 were identified from the Guide to Clinical Preventive Services, second edition and from high-quality reviews published in 1994 and in 1996; from reference lists of recent studies; and from experts.

NUMBER OF SOURCE DOCUMENTS

1,046 abstracts were reviewed; 54 studies were systematically abstracted; 47 additional studies were read but not systematically abstracted

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence on a 3-point scale (good, fair, or poor).

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Note: See the companion document titled "Current Methods of the U.S. Preventive Services Task Force: a Review of the Process" (Am J Prev Med 2001 Apr;20[3S]:21-35) for a more detailed description of the methods used to assess the quality and strength of the evidence for the three strata at which the evidence was reviewed.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF chair or liaisons on the topic team generally compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms it too close to justify a general recommendation.)

D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

COST ANALYSIS

A cost-effectiveness analysis of screening for malignant melanoma found that the average projected discounted life expectancy without screening was 15.0963, versus 15.0975 with screening. This difference is equivalent to an increase of about nine hours per person screened or 337 days for each person with melanoma.

Assuming that a screening examination by a dermatologist costs $30, the incremental cost-effectiveness (CE) ratio was $29,170 per year of life saved. The CE ratio was unexpectedly low because, in the model, savings from prevention of late-stage melanomas offset most of the costs of screening. Thus the key assumptions in the model, affecting the calculation of both effectiveness and cost, were that the proportion of late stage melanomas would decrease from 6.1% without screening to 1.1% with screening. Similarly, the model assumed invasive cancers would decrease from 70.3% to 58.1%, and melanomas thicker than 1.5 mm would decrease from 20.1% to 12.6% of invasive melanomas. These assumptions are based on comparison of cross-sectional data on the stages of melanoma in individuals who attended the American Academy of Dermatology's mass screening programs to data on usual care from the Surveillance, Epidemiology and End Results (SEER) registry.

From: Helfand M, Mahon SM, Eden KB, Frame PS, Orleans CT. Screening for skin cancer. Am J Prev Med 2001 Apr;20(3S):47-58 (see the "Companion Documents" field).

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review . Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations for skin cancer screening from the following groups were discussed: the Canadian Task Force on Preventive Health Care, the American Cancer Society, the American College of Preventive Medicine, the American College of Obstetricians and Gynecologists, a National Institutes of Health Consensus Panel, and the Australian National Health and Medical Research Council.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

- The US Preventive Services Task Force concludes that the evidence is insufficient to recommend for or against routinely screening for skin cancer using a total body skin examination for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer. I recommendation.

Evidence is lacking that skin examination by clinicians is effective in reducing mortality or morbidity from skin cancer. The US Preventive Services Task Force could not determine the benefits and harms of periodic skin examination. (See â œClinical Considerations' below for discussion of selected populations at high risk.)

Other strategies to prevent skin cancer, such as counseling to reduce risky health behaviors and performance of skin self-examination, will be addressed in a separate recommendation.

Clinical Considerations

- Benefits from screening are unproven, even in high-risk patients. Clinicians should be aware that fair-skinned men and women over age 65, patients with atypical moles and those with more than 50 moles constitute known groups at substantially increased risk for melanoma.
- Clinicians should remain alert for skin lesions with malignant features noted in the context of physical examinations performed for other purposes.
  Asymmetry, border irregularity, color variability, diameter greater than 6 mm (ABCD; see mole classification system below), or rapidly changing lesions are features associated with an increased risk of malignancy. Suspicious lesions should be biopsied.

  ABCD(E) system of mole classification:
  A: asymmetric
  B: irregular border
  C: varied color
  D: diameter greater than 6 mm
  E: elevation or enlargement

- The US Preventive Services Task Force did not examine the outcomes related to surveillance of patients with familial syndromes, such as familial atypical mole and melanoma syndrome.

Definitions:

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

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The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The US Preventive Services Task Force found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms it too close to justify a general recommendation.)

D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

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The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a 3-point scale (good, fair, or poor).

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Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number of power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting each recommendation is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Effectiveness of Early Detection

There are no randomized trials or case-control studies that directly examine whether screening by clinicians is associated with improved clinical outcomes such as morbidity or mortality from skin cancer. The possibility that earlier treatment as a result of screening improves health outcomes must rely on indirect evidence.

Screening consistently identifies melanomas that are, on average, thinner (i.e., at an earlier stage) than those found during usual care. It is not known if this stage shift leads to decreased morbidity or mortality. A case-control study in which skin self-examination was associated with a lower incidence of lethal melanoma provides indirect evidence that the shift to earlier stages found in screening may be associated with better clinical outcomes. Evidence from studies of the consequences of delay in diagnosis is inconsistent.

Even without formal screening programs, mortality from basal cell and squamous cell carcinoma is low compared to mortality from melanoma, but early detection and treatment may reduce morbidity and disfigurement from these cancers. No studies were found that evaluated whether screening improves the outcomes of these cancers.

Subgroups Most Likely to Benefit:

Elderly individuals

POTENTIAL HARMS

Potential Adverse Effects of Screening

There are no serious risks from total body skin examination but examination may be embarrassing to some patients and inconvenient in some settings. Screening could result in unnecessary treatment, either due to misdiagnosis or to detection of lesions that might not have caused clinical consequences. Screening also detects large numbers of benign skin conditions, which are very common in the elderly and could lead to additional biopsies and unnecessary or expensive procedures.

Subgroups Most Likely to be Harmed:

Elderly individuals

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Screening tests. Another screening strategy is to use a questionnaire or interview to assess risk factors such as family history and sun exposure and refer only high-risk patients for total-body skin examinations. Clinicians and patients can reliably measure some risk factors for melanoma, but the validity of formal risk assessment tools to screen unselected patients in primary care has not been established.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Neither the resources nor the composition of the U.S. Preventive Services Task Force (USPSTF) equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force (USPSTF) reports. The U.S. Preventive Services Task Force (USPSTF) convened representatives from the various audiences for the Guide - clinicians, consumers and policy makers from health plans, national organizations and Congressional staff - about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force (USPSTF) and Community Guide effort are conducting an audience analysis to further explore implementation needs. The Put Prevention into Practice initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force (USPSTF) materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force (USPSTF) products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals and test results are not always centralized.

RELATED QUALITY TOOLS

- Pocket Guide to Good Health for Adults

- A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening for skin cancer. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):44-6. [9 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2001 Apr)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or DHHS agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

The U.S. Preventive Services Task Force (USPSTF) consists of 13 experts from the specialties of family medicine, pediatrics, internal medicine, obstetrics and gynecology, geriatrics, preventive medicine, public health, behavioral medicine, and nursing. Members of the Task Force were selected from more than 80 nominees, based on recognized expertise in prevention, evidence-based medicine, and primary care.

Names of members: Alfred O. Berg, MD, MPH (Chair); Janet D. Alan, PhD, RN, CS, FAAN (Vice-Chair); Paul Frame, MD; Charles J. Homer, MD, MPH; Tracy A. Lieu, MD, MPH; Cynthia D. Mulrow, MD, MSc; Carole Tracy Orleans, PhD; Jeffrey F. Peipert, MD, MPH; Nola J Pender, PhD, RN, FAAN; Harold C Sox, Jr., MD; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H Woolf, MD, MPH

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Screening for skin cancer-including counseling to prevent skin cancer. In: Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. p. 141-52.

GUIDELINE AVAILABILITY

Electronic copies: Available from AJPM (American Journal of Preventive Medicine) Online. Additional information is available from the U.S. Preventive Services Task Force (USPSTF) Web site and the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Helfand M, Mahon SM, Eden KB, Frame PS, Orleans CT. Am J Prev Med 2001 Apr;20(3S):47-58. [83 references]
- Screening for skin cancer. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. (Systematic evidence review; no. 2) [103 references] (Electronic copies are only available in a downloadable format from the USPSTF Web site.)

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from the USPSTF Web site.

The following is also available:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality

(AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the AHRQ Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on April 6, 2001. The information was verified by the guideline developer as of April 10, 2001.

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